State of New Hampshire
Department of Health and Human Services

Request for Proposals (RFP) for
Multisystemic Therapy (MST)

Vendors Conference (*optional)*

DHHS Contracts Unit and
Division for Children, Youth and Families
January 20, 2021 from 10:00am to 12:00pm

Disclaimer

This presentation includes brief descriptions of the RFP specifications and requirements but does not fully elaborate on all required elements. As a result, this presentation does not supersede what is stated in the RFP or its appendices. Proposers are responsible for ensuring that their proposal is complete and accurate according to the information and requirements contained in the full RFP.

Today's agenda

10-10:10am	Welcome and overview of the meeting
10:10-10:35am	Overview of the MST program
10:35-11:00am	Q&A on MST program
11-11:30am	Overview of proposal contents and submission
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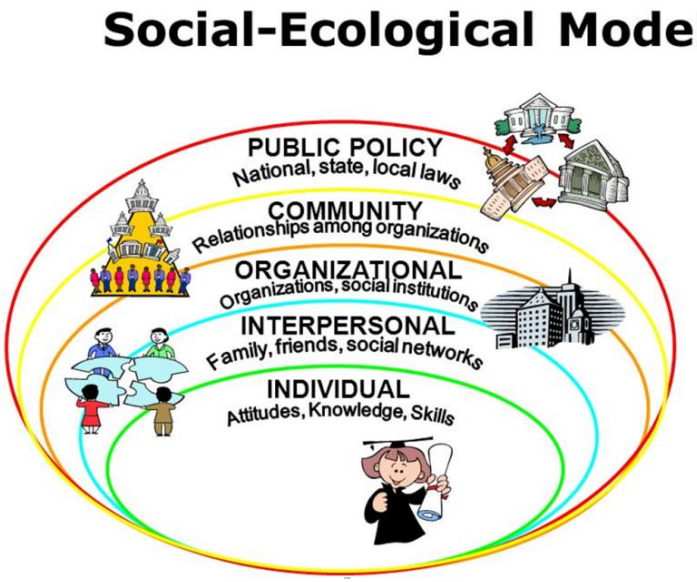
11:55-12:00am	Thanks, next steps, and close

To meet the needs of NH children and families, DHHS seeks to create a **broader, integrated child and family serving system**

"Child abuse and neglect is the result of the interaction of a number of individual, family, and environmental factors. Consequently, there is strong reason to believe that the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (e.g., public health, government, education, social services, and justice)."



Source: https://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html

Initial efforts to improve the service array include two initiatives: community-based voluntary services and new prevention services

Supplementing the service array with evidence-based program models and practices (EBPs)

	Community-based voluntary services (CBVS)	Prevention services
Initiative		
Goal	Safely prevent families from requiring DCYF intervention in the future	Prevent removals, stabilize reunifications, and maintain relative placements
Status	Contract in place, implementation begun. *Projected to begin serving families in early 2021. More information will be forthcoming as the rollout progresses.*	Beginning the process of adding five new evidence-based programs to the Service Array. More info can be found in the Procurement Forecast: https://www.dhhs.nh.gov/dcyf/documents/procurement-forecast-2020.pdf.

Anticipated set of investments is the product of **work within DCYF, across DHHS, and between DHHS and outside stakeholders**

Understanding needs (RFI and focus groups)

Learning about potential services (research and interviews)

Gauging demand for potential service models (case review)

Prioritizing the initial set of new service models

Plan, sequence, and develop procurements

Five EBPs in which DCYF intends to initially invest. These models would **not replace the existing service array, but supplement it**

MST® Multisystemic Therapy

Homebuilders®

Institute for Family Development

Intercept®

Youth VILLAGES® The force for families

Healthy Families America®

ChildParent Psychotherapy

"We hope that this forecast gives you the information you need to consider whether these services might be a fit for your organization…" (pg. 3)

Source: DCYF Procurement Forecast, 2020

We will focus on **two major areas** during this meeting

1. **Program goals and Scope of Work overview**

2. **Proposal contents and submission process**

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Today's overview will orient you to **DCYF's vision of success for the MST program and how vendors will be evaluated**

RFP sections discussed in overview:

- **Section 1,** Program goals and other strategic priorities
- **Section 2.1,** Covered populations
- **Section 2.2,** Scope of services
- **Section 2.4,** Performance improvement and performance metrics
- **Section 4.2,** Payment structure

The **overall outcome goal** of MST is to reduce the share of DCYF-involved youth who enter out-of-home care

The problem: While DCYF has decreased its reliance on juvenile detention and residential facilities in recent years, the Division is committed to reducing its reliance even further. In SFY 2020, 84% of youth served by JJS were served in their home communities while 16% were served in out-of-home care settings

FROM:	TO:
• Few available services tailored to the needs of JJ-involved families	• A services geared toward the needs of JJ-involved youth (or similar families in CPS)
• Many families having to wait to receive a intensive alternative to out-of-home care	• Rapid enrollment in services to prevent out-of-home placement
• Limited capacity to serve youth in home-based settings	• Strengthened capacity to serve youth in their home communities

MST outcome goal: Reduce the share of DCYF involved youth who enter out-of-home care

Source: Section 1.6., Program goals and strategic priorities

Other important priorities for MST – informed by DCYF's broader strategic priorities and responses to RFI in 2019

Family voice	Authentic engagement of caregivers, youth, and children in service provision is critical to effective services - **honoring family voice and empowering them is a core principle of the Multisystemic Therapy (MST) model**
Collaboration to improve service delivery	DCYF is looking for partners who want to collaborate closely to launch this new program. **In addition to the model fidelity/QA work lead by MST Services, LLC, MST providers will meet regularly with DCYF to improve service delivery over time**
Statewide service delivery	**DCYF is committed to ensuring MST is available in every community in NH including rural areas,** which pose additional service delivery challenges. **We encourage vendors to offer creative solutions to address these challenges** (e.g., telehealth, remote staffing, variable rates, sub-contracting)
Equity and inclusion	America's Juvenile Justice System operates in the context of a historical legacy of racial inequity. **DCYF is committed to delivering services equitably across all subpopulations, intends to collaborate with vendors to address those inequities** raised through MST's quality assurance and DCYF's contract management practice
Adequate funding	DCYF and RFI respondents both recognize the importance of paying what it takes to deliver results for new programs like MST. **We encourage applicants to thoughtfully articulate the variety of costs they will incur to provide MST**
Seamless coordination	MST must deliver services in a **seamless, highly coordinated way across the broader child and family serving system**. DCYF is committed to working with vendors to ensure handoffs are made seamlessly and that delivered in a coordinated manner

Source: Section 1.6., Program goals and strategic priorities

Target population: youth at high-risk of entering out-of-home care due to their behavioral health (primarily those involved with JJ)

Primary target population:

Multisystemic Therapy (MST) defines its eligible population as youth between the ages of 12 and 18 years old and who meet the following **general admission criteria**:

- Present with **significant externalizing behavioral health needs** (e.g., mental health and substance use) impacting the family, school/work, community domains; and
- Reside in a **family setting**

In addition, MST defines several exclusionary criteria. Please see Section 2.1 in the RFP for more info.

Estimated size of the target population:

In SFY19, roughly 300 youth and their families shared these target population characteristics. However, **DCYF is intentionally asking vendors to support MST to support 250 youth each year**

Key insights from analysis of target population needs:

- **Pop skews older:** ~54% of the identified youth were 16 and 17 years old; 70% were 15-17
- **Large share of youth likely to identify as people of color:** ~20-40% of the identified youth are people of color. DCYF does not know what % are limited English proficiency (LEP)
- **Concentrated in the Southern part of the state:** ~200 youth live in areas served by Manchester, Rochester, Seacoast, and Southern District Offices, ~ 100 live in areas served by remaining DOs
- **Mostly male:** 75% of the population identify as Male and 25% as female. DCYF does not have number concerning the number of trans or non-binary youth involved with JJS
- Because first-time offenders are often offered division, it is **safe to assume typically youth referred to MST from JJS will have some level of prior JJ involvement**.

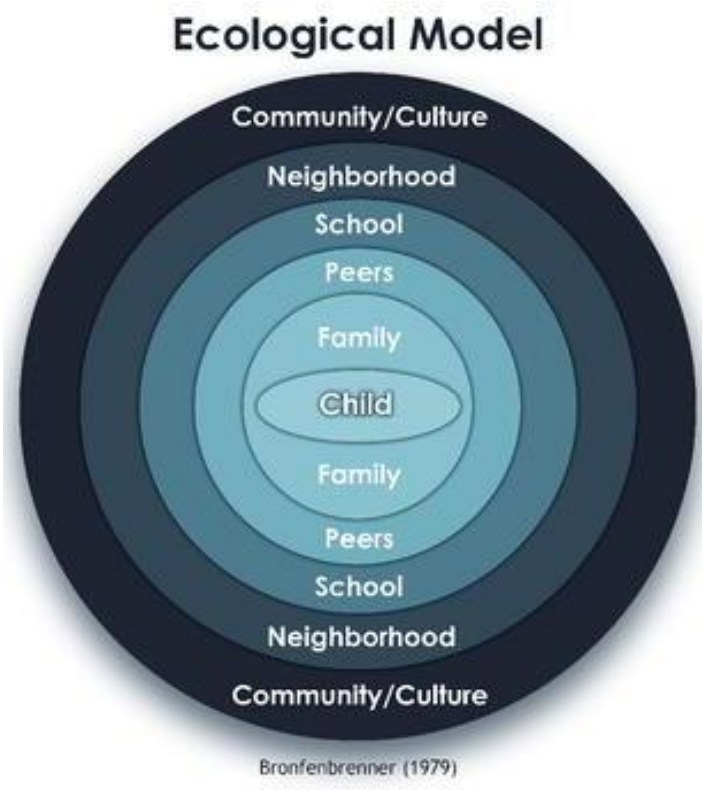
Source: Section 2.1., Covered populations and additional information the population

Major phases of MST program: overarching structure – more information to be shared by MST Services, LLC on January 21st

Top things to know about MST:

1. Therapists work in home, school, and community and a team member is available 24/7
2. Cases follow the MST Analytical Process to identify, treat, and monitor the needs of youth
3. Treatment lasts on average 120 days
4. Services are delivered through the parent to the youth. *Therefore, engaging parents/caregivers is essential to clinical success*
5. If hired as an MST clinician, they can only provide MST (dedicated to MST)
6. You will work closely with MST Services, LLC once the contract is signed

MST views the client as a network of systems including family, peers, school, and neighborhood



Source: MST Services, LLC

Payment structure: MST providers will be paid through three payment streams so that they are adequately funded

Start-up funds:	Daily rate:	Flexible funds:
The purpose of start-up funding is to support your organization as you launch your MST program. *Please refer to information in the RFP to determine what you should budget for services provided by MST Services, LLC during implementation (page 103 in the RFP)*	The purpose of the daily rate is to support the on-going delivery of services following the start-up and early moments of service delivery. *Please read the guidance provided in the RFP in developing your budget.*	DCYF has chosen to provide flexible funding worth $100 per family as part of this contract. *Vendors do not need to include flexible funds in their budget proposal, but must respond to all questions regarding flexible funds*
Paid near the beginning of the contract term at an amount negotiated with the vendor during contract negotiations	Paid under a process specified by DCYF at rate negotiated with vendor during contract negotiations. Vendors will also be required to bill Medicaid in a manner consistent with DCYF billing practices. DCYF process requires vendors to bill DCYF, rather than the DHHS Medicaid Fee for Service program, directly.	Either paid or incorporated into other funding streams; *DCYF will negotiate the precise terms of the flexible funding payment as part of contract negotiations*

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Evaluation and negotiation: Proposals will be evaluated against four categories and negotiations will finalize details

Criteria category:	**Points:**
Knowledge of MST and operational design	25 points possible
Organizational capacity	40 points possible
Performance improvement	25 points possible
Reasonable cost	10 points possible

DCYF reserves the right to select negotiate resulting contracts with each provider including:

- Final aspects of the payment structure (to ensure reasonable cost)
- Final catchment area for each provider (to ensure statewide access)

Source: Section 3, Technical and Cost Proposal Selection Criteria

We have updated requirements to **make it easier for you to submit strong proposals**

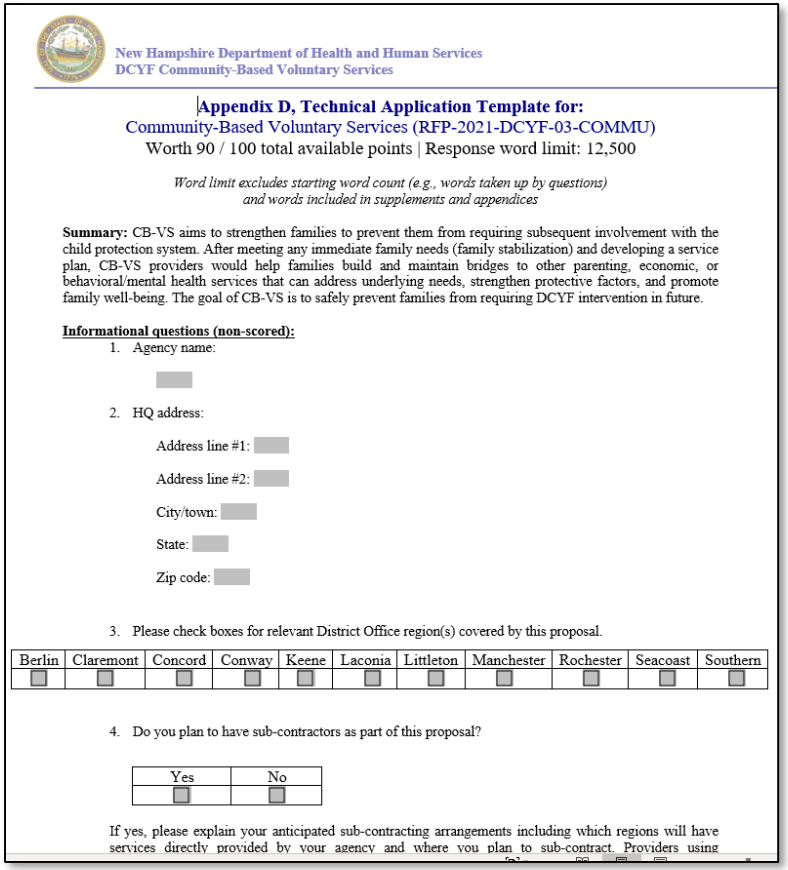
- **Entirely electronic submission process**
- **6-week response window** to allow your organizations to focus on developing high quality proposals
- **More time to identify sub-contractors** (e.g., not required until 30 days after G&C approval of the contract)
- **Easy-to-use response templates,** which we will show you more about during this presentation. *Please note that the templates were updated soon after posting the RFP. Please download new copies or check yours to make sure they are password protected*

MST proposals are broken into three parts – please see Appendix H and the RFP itself for more information

General contents	❑ Transmittal cover letter ❑ Proposers references ❑ New Hampshire Certificate of Good Standing ❑ Affiliations – Conflict of Interest ❑ Appendix C, CLAS Requirements
Technical application	❑ Appendix D, Technical Proposal
Cost application	❑ Appendix E, Budget Template ❑ Appendix F, Budget Narrative ❑ Appendix B, Contract Monitoring Provisions

Technical Proposal must be submitted using the provided template and is limited to 10,000 words

Appendix D. Technical Application



New Hampshire Department of Health and Human Services
DCYF Community-Based Voluntary Services

Appendix D, Technical Application Template for:
Community-Based Voluntary Services (RFP-2021-DCYF-03-COMMU)
Worth 90 / 100 total available points | Response word limit: 12,500

Word limit excludes starting word count (e.g., words taken up by questions) and words included in supplements and appendices

Summary: CB-VS aims to strengthen families to prevent them from requiring subsequent involvement with the child protection system. After meeting any immediate family needs (family stabilization) and developing a service plan, CB-VS providers would help families build and maintain bridges to other parenting, economic, or behavioral/mental health services that can address underlying needs, strengthen protective factors, and promote family well-being. The goal of CB-VS is to safely prevent families from requiring DCYF intervention in future.

Informational questions (non-scored):

1. Agency name:
2. HQ address:
   - Address line #1:
   - Address line #2:
   - City/town:
   - State:
   - Zip code:
3. Please check boxes for relevant District Office region(s) covered by this proposal.

Berlin	Claremont	Concord	Conway	Keene	Laconia	Littleton	Manchester	Rochester	Seacoast	Southern
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. Do you plan to have sub-contractors as part of this proposal?

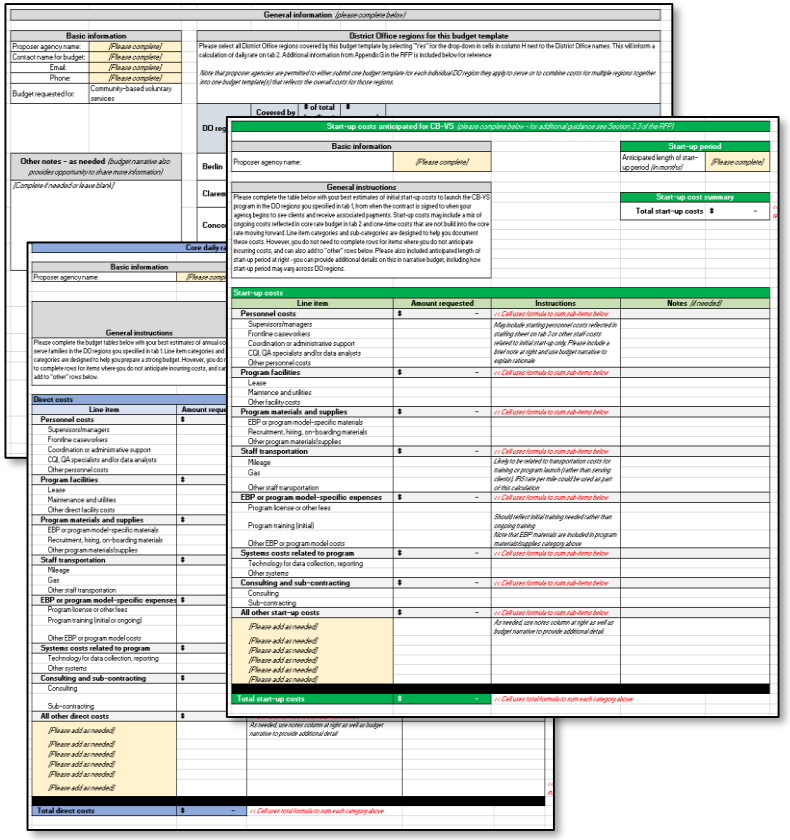
Yes	No
☐	☐

If yes, please explain your anticipated sub-contracting arrangements including which regions will have services directly provided by your agency and where you plan to sub-contract. Providers using

- **Fillable word document** that consolidates all the questions you need to answer *(reminder to make sure yours is fillable like a form)*
- You are required to **fully respond to all questions**
- Note the **10,000-word limit** (excluding the words in the document when you first open it)
- **Appendices and other supporting documents are allowed** and do not count toward your word limit

Budget Template is intended to help you identify and capture the different kinds of costs entailed in launching and implementing MST

Appendix F. Budget Template



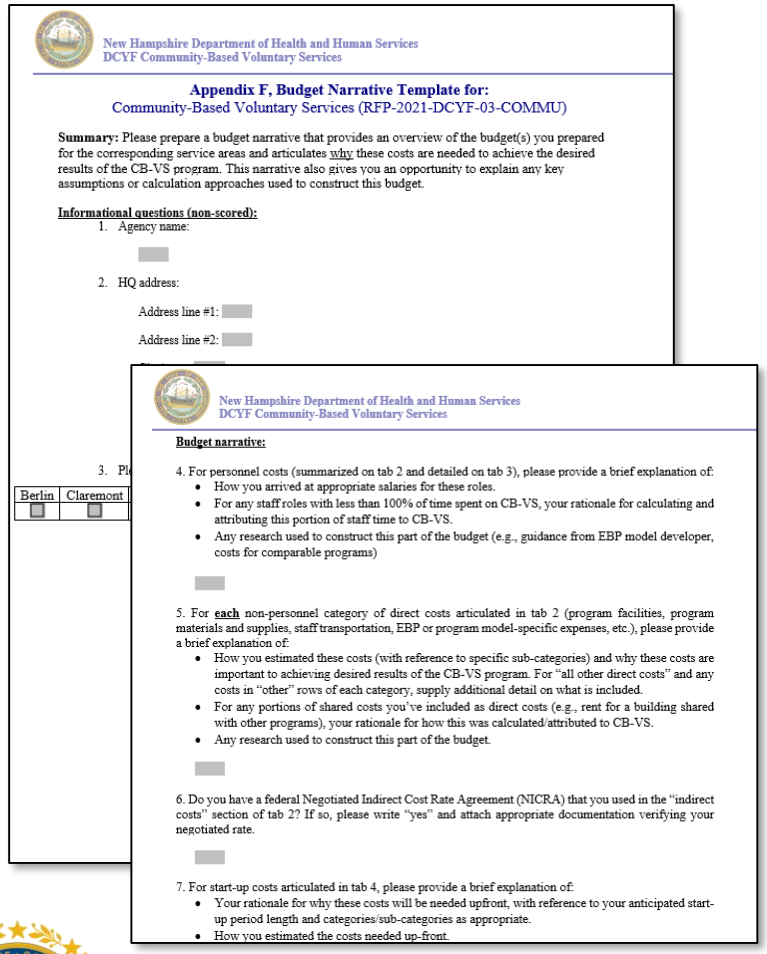
- **Excel document comprised of five sheets** *(reminder to make sure your copy is password protected/locked)*
  - Overview
  - General info (incl. regional selection)
  - Per diem rate budget
  - Staffing sheet
  - Start-up costs

- Budget will be scored based on **reasonable, thoughtful inclusion and articulation of costs** associated with a strong program

- **DCYF reserves the right to negotiate** several aspects of payment, including the final core rate. Start-up payments will also be allocated in a manner determined by DHHS

Budget Narrative must be submitted as accompanying detail to the budget template to provide a rationale for costs included

Appendix F. Budget Narrative



New Hampshire Department of Health and Human Services
DCYF Community-Based Voluntary Services

Appendix F, Budget Narrative Template for:
Community-Based Voluntary Services (RFP-2021-DCYF-03-COMMU)

Summary: Please prepare a budget narrative that provides an overview of the budget(s) you prepared for the corresponding service areas and articulates why these costs are needed to achieve the desired results of the CB-VS program. This narrative also gives you an opportunity to explain any key assumptions or calculation approaches used to construct this budget.

Informational questions (non-scored):

1. Agency name:
2. HQ address:
   Address line #1:
   Address line #2:
3. Pl

Berlin	Claremont
☐	☐

New Hampshire Department of Health and Human Services
DCYF Community-Based Voluntary Services

Budget narrative:

4. For personnel costs (summarized on tab 2 and detailed on tab 3), please provide a brief explanation of:
   - How you arrived at appropriate salaries for these roles.
   - For any staff roles with less than 100% of time spent on CB-VS, your rationale for calculating and attributing this portion of staff time to CB-VS.
   - Any research used to construct this part of the budget (e.g., guidance from EBP model developer, costs for comparable programs)

5. For **each** non-personnel category of direct costs articulated in tab 2 (program facilities, program materials and supplies, staff transportation, EBP or program model-specific expenses, etc.), please provide a brief explanation of:
   - How you estimated these costs (with reference to specific sub-categories) and why these costs are important to achieving desired results of the CB-VS program. For "all other direct costs" and any costs in "other" rows of each category, supply additional detail on what is included.
   - For any portions of shared costs you've included as direct costs (e.g., rent for a building shared with other programs), your rationale for how this was calculated/attributed to CB-VS.
   - Any research used to construct this part of the budget.

6. Do you have a federal Negotiated Indirect Cost Rate Agreement (NICRA) that you used in the "indirect costs" section of tab 2? If so, please write "yes" and attach appropriate documentation verifying your negotiated rate.

7. For start-up costs articulated in tab 4, please provide a brief explanation of:
   - Your rationale for why these costs will be needed upfront, with reference to your anticipated start-up period length and categories/sub-categories as appropriate.
   - How you estimated the costs needed up-front.

- **Fillable word document** *(reminder to make sure yours is fillable like a form)*
- **No word limit** assigned, but we do encourage you to be mindful of length
- Budget narratives should focus on **why** these costs are needed to achieve desired program results and **how** you calculated/compiled them
- **NICRA:** Agencies with a federal NICRA should include NICRA documentation as a supplement to the cost portion of your proposal. If you do not have a NICRA, please indicate "No" to question 6

Submission process overview

- Proposals **must be submitted electronically** to contracts@dhhs.nh.gov with Jennifer Hackett (Jennifer.hackett@dhhs.nh.gov) cc'd on the email
- The **subject line of your email** must include the RFP name (RFP-2021-DCYF-04-MULTI)
- If you plan to submit with multiple emails, **please number your emails** (e.g., RFP-2021-DCYF-04-MULTI 1 of 5)
- As a reminder, the maximum size of files per email is 10MB, meaning **you will likely need to send multiple emails or use a zip folder**
- **For those who haven't used zip folders:** Right click on the desktop, select new, select zip folder, name the folder, and drop your contents in

Proposals are due by e-mail on February 25. Between now and then, we'll be putting out an QA with question responses

All times are according to EST. DHHS reserves the right to modify these dates at its sole discretion.		
Item	Action	Date
1.	Release RFP	January 14, 2021
2.	RFP Vendor Conference (optional)	January 20, 2021
3.	Information Session by MST Services, LLC (optional/ recorded)	January 21, 2021
4.	RFP Questions Submission Deadline	January 25, 2021 at **2:00 PM**
5.	Department Response to Questions Published	February 5, 2021
6.	Proposal Submission Deadline	February 25, 2021 at **11:59 PM**

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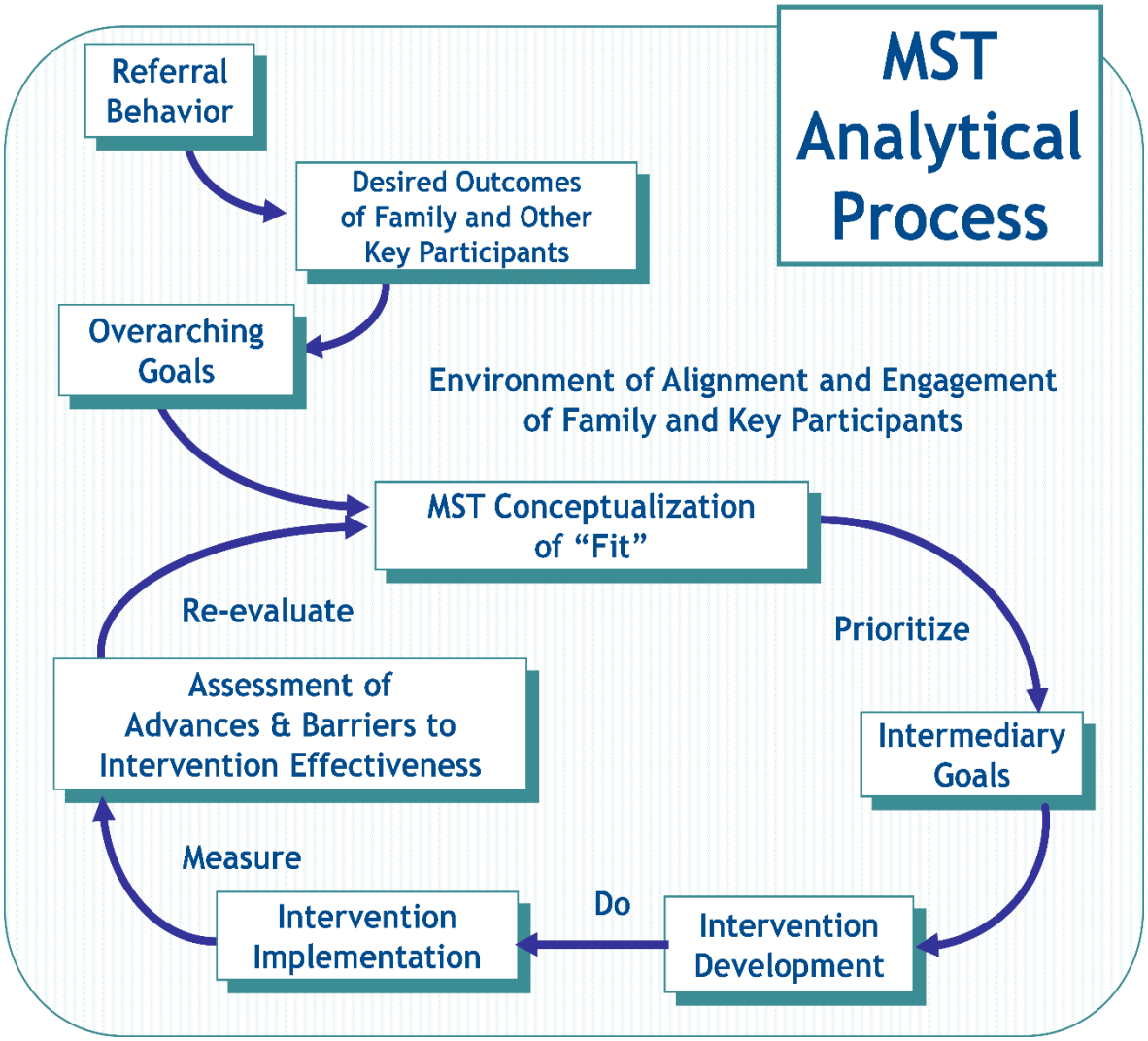
APPENDIX:

Figure 2: MST analytic process (also known as the "Do-Loop")



Source: RFP-2021-DCYF-03-COMMU, page 7

Figure 3: 9 Principles of MST

In addition to the analytical process, the MST program adheres to 9 Principles, which MST uses to guide intervention design and implementation. The continuous evaluation of treatment fidelity and adherence centers around these nine principles.

1. **Finding the fit:** The purpose of the assessment is to understand the fit between the identified problems and their broader systemic context
2. **Positive and strength-focused:** Therapeutic contracts should emphasize the positive and should use systemic strengths as levers for change.
3. **Increasing responsibility:** Interventions should be designed to promote responsibility and decrease irresponsible behavior among family members
4. **Present-focused, Action-oriented, and Well-defined:** Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
5. **Targeting sequences:** Interventions should target sequences of behavior within and between multiple systems that maintain identified problems.
6. **Developmentally appropriate:** Interventions should be developmentally appropriate and fit the developmental needs of the youth.
7. **Continuous effort:** Interventions should be designed to require daily or weekly effort by family members.
8. **Evaluation and accountability:** Intervention efficacy is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.
9. **Generalization:** Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

Source: RFP-2021-DCYF-03-COMMU, page 7

Performance metrics to measure success and track progress along the way

Key performance metrics:
Before the first face-to-face meeting
• Share of referred youth who do/do not enroll in MST (and reason for rejection) • Share of referred youth who receive a face-to-face within three days of referral
While enrolled in Multisystemic Therapy
• Share of enrolled youth who commit new offenses while enrolled in MST • Share of enrolled youth with technical violations filed while enrolled in MST • Share of youth who are placed into shelter care/another type of short-term care while enrolled in MST
At discharge from Multisystemic Therapy
• Share of youth who do/do not complete the program (incl. reason for non-completion)
Short-term outcomes
• Share of youth who remain involved with JJS 3 months after discharge • Share of youth with a new case opened to JJS within six months after discharge • Share of youth who enter placement within six months after discharge
Longer-term outcomes:
• Share of youth with a case opened to JJS within 12 months of discharge • Share of youth who enter any form of placement within 12 of discharge

Key output and process metrics:

- # of youth currently enrolled in MST and % of MST slots currently used
- # of youth who receive a warm handoff to the MST provider
- # of referrals, including the number in the target population (e.g., JJ-involved youth, risk of placement) and % of referrals in the MST defined target population
- # of enrollees, including the number in the defined target population and % of enrollees in the MST defined target population
- # of days from DCYF assessment start date to referral date
- # of days from referral date to the first face-to-face

Source: XXX